SOAH DOCKET NO. _____

LICENSE NO. H-2532

IN THE MATTER OF	§	BEFORE THE
	§	
THE COMPLAINT AGAINST	§	
	§	TEXAS STATE BOARD
ADOLPHUS RAY LEWIS, D.O.,	§	
	§	
RESPONDENT	§	OF MEDICAL EXAMINERS

COMPLAINT

TO: THE HONORABLE TEXAS STATE BOARD OF MEDICAL EXAMINERS AND THE HONORABLE ADMINISTRATIVE LAW JUDGE TO BE ASSIGNED.

The Staff of the Texas State Board of Medical Examiners ("Board Staff" or "Staff"), by and through the undersigned attorney of record, files this Complaint against Adolphus Ray Lewis, D.O. ("Respondent"), based on Respondent's alleged violation(s) of the Medical Practice Act ("Act"), TEX. REV. CIV. STAT. ANN., art. 4495b (Vernon Supp. Pamphlet 1997), and in support of this Complaint and based upon information and belief, would show the following:

I

The filing of this Complaint against Respondent, Adolphus Ray Lewis, D.O., and the relief requested herein are necessary to protect the health and welfare of the citizens of the State of Texas as mandated by Section 1.02 of the Act.

II

1. Respondent is a licensed Texas physician.

2. Respondent was issued a Texas medical license by the Texas State Board of Medical Examiners ("the Board") on February 5, 1988.

3. Respondent's Texas medical license bears number H-2532.

4. Respondent's mailing address on file with the Board is 4732 East Lancaster Street, Suite A, Fort Worth, Texas 76103.

5. All personal and subject matter jurisdictional requirements have been satisfied.

III

Board Staff has received information which indicates that Respondent may have violated the Act. Upon the basis of such information, Board Staff files this Complaint and thereby charges and alleges that:

COUNT 1

PATIENT A.T.

1. On or about July 29, 1994, A.T., an adult male patient in his fifties, was first seen for medical treatment by Respondent.

2. A.T. was diagnosed with a lipoma of the right shoulder, back pain, and degenerative joint disease.

3. The patient A.T. was already taking Vicodin and Valium, which he had received from another source, when he initially consulted Respondent for his ailments.

4. Respondent referred A.T. to another doctor. However, on subsequent visits of A.T. to Respondent, usually monthly, Respondent prescribed Valium 10 mg #90 and Vicodin #90 for A.T.

5. The medical records do not reflect that any tests were performed prior to the prescribing of the narcotics outlined in paragraph 4, herein.

6. On or about December 15, 1994, A.T. had a large lipoma removed and did not return to see Respondent until March, 1995. At that time, A.T. complained of stress and fluid on his knee. Respondent prescribed Valium for tension, drained the fluid from the knee, and prescribed Vicodin for the pain. Respondent also prescribed Hytrin for a blood pressure of 148 over 98.

7. A.T. last saw Respondent on or about May 24, 1995 with complaints of knee pain.

8. From July, 1994 to May, 1995, Respondent prescribed medically excessive quantities of controlled substances, namely Valium and Vicodin to A.T.

9. Throughout the physician-patient relationship between Respondent and A.T.,

Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking adequate initial and interval medical histories of A.T., without performing a medically adequate medical examination of A.T., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating the medical rationale for the prescriptions.

10. Respondent's prescribing of those controlled substances to A.T. was without adequate medical indication and without adequate legitimate medical rationale.

11. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes writing prescriptions for or dispensing to a person known to be an abuser of narcotic drugs, controlled substances, or dangerous drugs or to a person who the physician knew or should have known was an abuser of the narcotic drugs, controlled substances, or dangerous drugs.

12. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

13. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

14. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 2

PATIENT C.C.

1. On or about July 28, 1993, C. C., an adult female in her twenties, was first seen by Respondent with complaints of weight control and high blood pressure.

2. There was no physical examination performed or adequately documented, according the medical records. Also, there was no adequate treatment plan included in the medical records of

C.C.

3. Respondent began prescribing Valium and Vicodin for C.C. on September 19, 1994.

4. The diagnosis of high blood pressure is not adequately supported in the medical records. C.C.'s blood pressure records reflect the following readings:

7/28/93 BP 130/94

8/15/94 BP 110/86

9/19/97 BP 124/74

5. There is inadequate documentation on the progress note record of the prescriptions provided, nor is there adequate medical indication for the Vicodin and Valium prescriptions given to C.C.

6. On or about October 24, 1994, C.C. visited Respondent with complaints of pain in the left side of her abdomen. The records do not adequately indicate any assessment of this pain. The patient was provided with Vicodin ES #90, Valium 10 mg #90, Bromfed DM 6 oz. There is inadequate documentation for these prescriptions on the progress note records, and inadequate indication for these medications.

7. On or about December 7, 1994, C.C. visited Respondent with complaints of a cold, cough, and congestion for 1 to 1 ½ weeks. No physical examination is adequately documented and no lab work is adequately documented. There is inadequate listing of prescriptions on the progress note records, and yet Respondent prescribed Phenergan DM #6 oz, Amoxicillin 500 mg. #30, Vicodin ES #90, and Valium 10 mg #90. The diagnosis is listed as HTN.

8. On or about January 23, 1995, C.C. returned with complaints of an infection under her chin and back pain. There is inadequate assessment of her pain, yet Respondent provided C.C. with a prescription for Vicodin ES #90.

9. On or about April 28, 1995, CC. returned but the complaint and examination is not adequately documented in the chart. There are two diagnoses, but only Impetigo is legible. The prescriptions provided to C.C. on this visit included Phenergan DM #6 oz., Vantin 100 mg/5ml, Vicodin ES #90, Valium 10 mg. #90. Included in C.C.'s patient chart are copies of prescriptions for another patient.

10. From July, 1993 to April, 1995, Respondent prescribed medically excessive quantities

of controlled substances to C.C..

11. Throughout the physician-patient relationship between Respondent and C.C., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of C.C., without performing or documenting a medically adequate medical examination of C.C., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

12. Respondent's prescribing of those controlled substances to C.C. was without adequate medical indication and without adequate legitimate documented medical rationale.

13. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

14. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

15. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 3

PATIENT G.T.

1. On or about April 27, 1994, patient G.T., an adult male, was first seen by Respondent with complaints of back pain, bronchitis, nasal congestion and high blood pressure.

2. There is not adequate indication in the medical records that a physical examination was performed on G.T. No laboratory tests were ordered and noted in the medical records.

3. G.T. saw Respondent from approximately April 27, 1994 until September 2, 1995.

On each visit, Respondent provided G.T. with a prescription for Vicodin #90 with one refill. On each visit, Respondent also provided G.T. with a prescription for Valium 10 mg. #90.

4. Although high blood pressure was listed as a diagnosis, no blood pressure medication was ordered. Respondent did not adequately address this complaint.

5. There is a prescription for G.T. dated September 2, 1995, but there is no corresponding office visit.

6. From April, 1994 to September, 1995, Respondent prescribed medically excessive quantities of controlled substances, namely Valium and Vicodin, to G.T.

7. Throughout the physician-patient relationship between Respondent and G.T., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of G.T., without performing or documenting a medically adequate medical examination of G.T., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

8. Respondent's prescribing of those controlled substances to G.T. was without adequate medical indication and without adequate legitimate documented medical rationale.

9. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

10. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

11. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 4

PATIENT R.C.

1. On or about April 26, 1993, R.C., an adult male in his thirties, first saw Respondent with complaints of post trauma causalgia, which is intense burning pain accompanied by trophic skin changes, due to injury of nerve fibers. Respondent prescribed Vicodin and Valium, #60 each.

2. On subsequent visits, Respondent prescribed a total of approximately 1320 Valium tablets, 1716 Vicodin tablets, 360 Soma tablets, 300 Xanax tablets, and 58 ounces of Phenergan with codeine to R.C.

3. There is not adequate indication in the medical records for R.C. that adequate laboratory testing was undertaken to justify these prescriptions.

4. There is not adequate indication in the medical records for R.C. that any physical examination was performed.

5. There were copies of other patient's prescriptions found within the medical records for R.C. These other prescriptions were for the same medications on the same dates, but with different patient names.

6. From April, 1993 to April, 1995, Respondent prescribed medically excessive quantities of controlled substances to R.C.

7. Throughout the physician-patient relationship between Respondent and R.C., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of R.C.., without performing or documenting a medically adequate medical examination of R.C., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

8. Respondent's prescribing of those controlled substances to R.C. was without adequate medical indication and without adequate legitimate documented medical rationale.

9. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

10. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

11. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 5

PATIENT S.Y.

1. On or about September 9, 1987, S.Y., an adult female, began seeing Respondent with complaints of anxiety and migraine headaches.

2. In June of 1989, Medicaid contacted Respondent and placed S.Y. in a Lock-In program, which is initiated when a patient sees too many doctors.

3. Beginning on or about February 20, 1990, Respondent prescribed Vicodin #60 to S.Y. for complaints of low back pain and headache.

4. On or about March 5, 1990, S.Y. again saw Respondent with complaints of headache and anxiety. S.Y. was given a prescription for Vicodin with no number of tablets documented.

5. On or about July 16, 1990, S.Y. reported to Respondent that the Vicodin was not tolerated well. Respondent prescribed Wygesic. On or about July 26, 1990, Respondent prescribed Darvon to S.Y.

6. On or about August 22, 1990, S.Y. returned to see Respondent and was prescribed Vicodin for her complaints.

7. On or about January 9, 1991, S.Y. was given a prescription by Respondent for Vicodin #60. On or about January 14, 1991, S.Y. complained of intolerance and was given a prescription for Darvon by Respondent.

8. On or about February 4, 1991, S.Y. again presented with complaints of migraine headaches, and was once again prescribed Vicodin.

9. S.Y. was seen in the ER by another physician, a neurologist, after she suffered a seizure. She was placed on Dilantin by the ER physician. Respondent's records do not reflect the cause of the seizures nor any test results. However, Respondent began prescribing Dilantin to S.Y., and over a period of time, the amount of Dilantin prescribed was increased.

10. On or about January 26, 1994, S.Y. presented with cramping of her foot and Respondent prescribed Tylenol #4, 120 tablets.

11. On or about February 25, 1994, S.Y. complained of bilateral foot pain and received a prescription for Tylenol #3, 120 tablets.

12. On or about July 11, 1994, S.Y. presented with an infected wound and depression. She received prescriptions for Soma #120 and Vicodin #120 from Respondent.

13. On or about August 24, 1994, S.Y. died following respiratory arrest. The drugs implicated were Carisoprodol (Soma), Meprobamate (Miltown), and Propoxyphene (Darvon).

14. From February, 1990 to August, 1994, Respondent prescribed medically excessive quantities of controlled substances to S.Y.

15. Throughout the physician-patient relationship between Respondent and S.Y., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of S.Y., without performing or documenting a medically adequate medical examination of S.Y., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

16. Respondent's prescribing of those controlled substances to S.Y. was without adequate medical indication and without adequate legitimate documented medical rationale.

17. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes writing prescriptions for or dispensing to a person known to be an abuser of narcotic drugs, controlled substances, or dangerous drugs or to a person who the physician knew or should have known was an abuser of the narcotic drugs, controlled substances, or dangerous drugs.

18. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are

prescribed.

19. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

20. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 6

PATIENT J.L.

1. In January, 1993, J.L., an adult male, initially consulted Respondent complaining of right shoulder pain.

2. Respondent began prescribing Valium, Vicodin, Percodan and Lorcet to the patient.

3. Over the course of the physician/patient relationship, until January of 1994, Respondent wrote 61 prescriptions for J.L. The amount of Vicodin prescribed was enough for J.L. to take six (6) tablets per day. The following prescription quantities have been calculated for patient J.L.:

Valium:	1269 tablets
Vicodin:	1600 tablets
Percodan:	420 tablets
Lorcet:	50 tablets

4. Respondent did not follow the Board's guidelines for chronic pain management in his treatment of patient J.L.

5. Respondent terminated the physician/patient relationship on or about January 20, 1994 due to suspected drug abuse by patient J.L.

6. From January, 1993 to January, 1994, Respondent prescribed medically excessive quantities of controlled substances, namely Valium, Percodan, Lorcet and Vicodin, to J.L.

7. Throughout the physician-patient relationship between Respondent and J.L., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of J.L., without performing or documenting a medically adequate medical examination of J.L., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

8. Respondent's prescribing of those controlled substances to J.L. was without adequate medical indication and without adequate legitimate documented medical rationale.

9. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes writing prescriptions for or dispensing to a person known to be an abuser of narcotic drugs, controlled substances, or dangerous drugs or to a person who the physician knew or should have known was an abuser of the narcotic drugs, controlled substances, or dangerous drugs.

10. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

11. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

12. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 7

PATIENT B.S.

1. Patient B.S., a 67 year old adult female, reportedly suffered from colon cancer, although this is not confirmed nor reflected in the patient's medical records.

2. B.S. also suffered from multiple system failure with congestive heart failure,

hypertension, angina, and diabetes mellitus.

3. Respondent prescribed Percodan for patient B.S. from June of 1994, until May of 1995. The quantity would be between 60 and 120 per month.

4. From June, 1994 to May, 1995, Respondent prescribed medically excessive quantities of controlled substances, namely Percodan, to B.S.

5. Throughout the physician-patient relationship between Respondent and B.S., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of B.S., without performing or documenting a medically adequate medical examination of B.S., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

6. Respondent's prescribing of those controlled substances to B.S. was without adequate medical indication and without adequate legitimate documented medical rationale.

7. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

8. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

9. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 8

PATIENT B.P.

1. Patient B.P., an adult female, initially consulted Respondent on or about April 27,

1994 with complaints of joint pain and weight control. Respondent diagnosed her with osteoporosis and arthritis. He recommended the patient lose weight.

2. The records fail to adequately indicate that a physical examination had been conducted, failed to adequately indicate that any lab work had been completed, and failed to adequately indicate the medical indications that would justify the large amounts of medications which were ultimately prescribed. In some cases, there was no documented patient complaint at all.

3. Respondent prescribed Tylenol #4 and Percodan to treat B.P.'s conditions. These medications were not adequately indicated for the diagnoses B.P. had been given.

4. From April, 1994 to May, 1995, Respondent prescribed medically excessive quantities of controlled substances to B.P.

5. Throughout the physician-patient relationship between Respondent and B.P., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of B.P., without performing or documenting a medically adequate medical examination of B.P., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

6. Respondent's prescribing of those controlled substances to B.P. was without adequate medical indication and without adequate legitimate documented medical rationale.

7. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

8. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

9. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the

professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 9

PATIENT G.P.

1. G.P., an adult male, originally consulted Respondent with complaints of arthritis and degenerative joint disease in 1994.

2. Respondent failed to refer G.P. to a rheumatologist.

3. Respondent instead treated G.P. through prescription medications, specifically, Demerol.

4. From October, 1994 to November, 1994, Respondent prescribed medically excessive quantities of controlled substances, namely Demerol, to G.P.

5. Throughout the physician-patient relationship between Respondent and G.P., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of G.P., without performing or documenting a medically adequate medical examination of G.P., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

6. Respondent's prescribing of those controlled substances to G.P. was without adequate medical indication and without adequate legitimate documented medical rationale.

7. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

8. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

9. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

COUNT 10

PATIENT L.J.

1. L.J., an adult male, consulted Respondent for the first time on or about April 13, 1994 for back pain, shoulder pain, sinusitis and migraines.

2. The medical records fail to adequately, reflect proper lab testing, x-rays or other diagnostic tests. There also is inadequate documented physical examination or complete medical history on this patient.

3. Respondent prescribed large amounts of Vicodin, Doral, Soma, Lorcet, Ceftin, Inderal Tylenol #3 and Xanax to L.J. without adequate medical indications.

4. Within a 16 month time period, Respondent prescribed 540 Vicodin, 2070 Soma, 1260 Lorcet, 20 Ceftin, 90 Inderal, 90 Tylenol #3 and 240 Xanax to patient L.J.

5. Some of the prescriptions referenced in #4 herein are not dated.

6. From April, 1994 to July, 1995, Respondent prescribed medically excessive quantities of controlled substances to L.J.

7. Throughout the physician-patient relationship between Respondent and L.J., Respondent prescribed on a continuous and frequent basis quantities of controlled substances and/or dangerous drugs without taking or documenting an adequate initial and interval medical histories of L.J., without performing or documenting a medically adequate medical examination of L.J., including medically appropriate diagnostic testing/studies, without adequately reassessing the patient medically, and/or without adequately reevaluating or documenting the medical rationale for the prescriptions.

8. Respondent's prescribing of those controlled substances to L.J. was without adequate medical indication and without adequate legitimate medical rationale.

9. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drugs are prescribed.

10. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes prescribing in a manner not consistent with public health and welfare controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481 of the Texas Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513).

11. Respondent's aforedescribed conduct, including acts and/or omissions, constitutes the professional failure to practice medicine in an acceptable manner consistent with the public health and welfare.

IV

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 1 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (C), 3.08 (4) (E), 3.08(4)(F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

V

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 2 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (E), 3.08 (4) (F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

VI

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 3 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (E), 3.08 (4) (F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

VII

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 4 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (E), 3.08 (4) (F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

VIII

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 5 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (C), 3.08 (4) (E), 3.08(4)(F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

IX

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 6 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (C), 3.08 (4) (E), 3.08(4)(F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

X

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 7 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (E), 3.08 (4) (F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

XI

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 8 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (E), 3.08 (4) (F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

XII

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 9 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (E), 3.08 (4) (F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

XIII

It is further alleged that Respondent's conduct, including actions and/or omissions, as described in Count 10 herein, collectively and singularly, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any authorized means of discipline upon Respondent pursuant to Sections 3.08 (4) (E), 3.08 (4) (F), 3.08 (18), 4.01 (a), 4.12 and 4.125 of the Act.

XIV

Section 3.08 (4) of the Act authorizes the Board to discipline a licensed Texas physician for "unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public."

XV

Section 3.08 (4) (C) of the Act authorizes the Board to discipline a licensed Texas physician

for "writing prescriptions for or dispensing to a person known to be an abuser of narcotic drugs, controlled substances, or dangerous drugs or to a person who the physician should have known was an abuser of the narcotic drugs, controlled substances, or dangerous drugs."

XVI

Section 3.08 (4) (E) of the Act authorizes the Board to discipline a licensed Texas physician for "prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed."

XVII

Section 3.08 (4) (F) of the Act authorizes the Board to discipline a licensed Texas physician for "prescribing, administering, or dispensing in a manner not consistent with public health and welfare dangerous drugs as defined by Chapter 483, Health and Safety Code, controlled substances scheduled in the Texas Controlled Substances Act (Chapter 481, Health and Safety Code), or controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513)."

XVIII

Section 3.08 (18) of the Act authorizes the Board to discipline a licensed Texas physician for "professional failure to practice medicine in an acceptable manner consistent with public health and welfare."

XIX

Section 4.01(a) of the Act authorizes the cancellation, revocation, suspension and probation of a physician's Texas license for a violation of the Act or a rule of the Board of for any cause for which the Board is authorized to refuse to admit persons to its examination and to issue a license or renewal license.

XX

Section 4.12 of the Act authorizes a range of disciplinary actions against a licensed Texas physician for committing any of the conduct set forth in Section 3.08 of the Act.

XXI

Section 4.125 of the Act authorizes the Board to impose upon a licensed Texas physician a monetary administrative penalty not to exceed five thousand dollars ($5,000.00) for each separate violation of the Act or Board rule by a person licensed or regulated under the Act. In addition to such other disciplinary action authorized by the Act, Board staff seeks an administrative penalty in the amount of at least $82,500. [$2,500 for each Count's violations].

XXII

Respondent's alleged violations of Sections 3.08 (4) (C) , 3.08 (4) (E), 3.08 (4) (F), and 3.08 (18), as described in the above Counts 1 through 10, are grounds, collectively and singularly, for the Board to enter an Order in regard to Respondent and Respondent's medical license pursuant to Sections 4.01(a), 4.12 and 4.125 of the Act.

WHEREFORE, PREMISES CONSIDERED, Board Staff prays that a contested case hearing on the merits of this Complaint be held and that upon the trial of the matters asserted herein that an Order be entered revoking or suspending Respondent's Texas medical license, or in the event that Respondent's Texas medical license is not revoked or suspended, Board Staff then, in the alternative,

prays that the appropriate sanction and remedy be imposed on Respondent and Respondent's Texas medical license.

Respectfully submitted,

By: Susan H. Oswalt

Susan H. Oswalt
Texas State Bar No. 00797834
Staff Attorney for the
Texas State Board of Medical Examiners
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701
Mailing address:
P. O. Box 2018
Austin, Texas 78768-2018
(512) 305-7082
(512) 305-7007 (FAX)

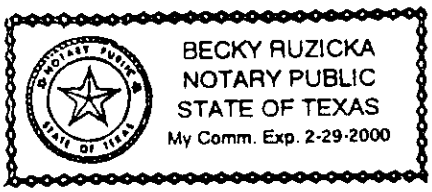
THE STATE OF TEXAS §
§
COUNTY OF TRAVIS §

VERIFICATION

On this day personally appeared before me, the undersigned notary public, Susan H. Oswalt, in the capacity of Staff Attorney and upon her oath stated that she is familiar with the allegations advanced in the above Complaint and that the Complaint is made for the sole purpose of enforcing the Medical Practice Act of the State of Texas, article 4495b, Texas Revised Civil Statutes Annotated. Further Affiant sayeth not.

Susan H. Oswalt
in the capacity of Staff Attorney for the Texas State Board of Medical Examiners

SUBSCRIBED AND SWORN to before me by the said Susan H. Oswalt, on this the 29th day of September, 1997.



Becky Ruzicka
Notary Public, State of Texas

Filed with the Texas State Board of Medical Examiners on this the 29th day of September 1997.

Bruce A. Levy, M.D., J.D.
Executive Director
Texas State Board of Medical
Examiners

CERTIFICATE OF SERVICE

I certify that on this 29th day of September, 1997, a true and correct copy of the foregoing Complaint together with the Verification has been served on the following individuals at the locations and in the manner indicated below:

Adolphus Ray Lewis, D.O.
4732 East Lancaster St., Suite A
Fort Worth, Texas 76103
(VIA CERTIFIED MAIL - RETURN RECEIPT REQUESTED)

Adolphus Ray Lewis, D.O.
P.O. Box 170369
Arlington, Texas 76009-0369
(VIA CERTIFIED MAIL - RETURN RECEIPT REQUESTED)

Rommel Corro, Docket Clerk
State Office of Administrative Hearings
William P. Clements Building
300 W. 15th St., Suite 504
Austin, Texas 78701-1649
(VIA CERTIFIED MAIL - RETURN RECEIPT REQUESTED)

Hearings Department
Texas State Board of Medical Examiners
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78711
(VIA HAND-DELIVERY)

Susan H. Oswalt
Staff Attorney

LICENSE NO. H-2532

IN THE MATTER OF	BEFORE THE
THE LICENSE OF	TEXAS STATE BOARD
ADOLPHUS LEWIS, D.O.	OF MEDICAL EXAMINERS

AGREED ORDER

On this the 22 day of August, 1998, came on to be heard before the Texas State Board of Medical Examiners ("the Board"), duly in session the matter of the license of Adolphus Lewis, D.O. ("Respondent"). On October 17, 1996 Respondent appeared in person with counsel, Terry Lewis, at an Informal Settlement Conference/Show Compliance Proceeding in response to a letter of invitation from the staff of the Board.

The Board was represented at the Informal Settlement Conference/Show Compliance Proceeding by Cynthia Jenkins and Russell Thomas, Jr., D.O., members of the Board. Upon recommendation of the Board's representatives, and with the consent of Respondent, the Board makes the following findings of fact and conclusions of law and enters this Order as set forth herein:

FINDINGS OF FACTS

1. Respondent, Adolphus Ray Lewis, D.O. holds Medical license H-2532.

2. The Board has jurisdiction over the subject matter and Respondent. Respondent received all notice which may be required by law and by the rules of the Board. All jurisdictional requirements have been satisfied.

3. Respondent was issued a Texas medical license by the Texas State Board of Medical Examiners ("the Board") on February 5, 1988.

4. Respondent routinely treats chronic pain patients and patients who have otherwise

failed alternative treatment modalities.

5. Respondent is the Medical Director for a hospice and in those activities, treats terminally ill patients.

6. Respondent also focuses his practice on geriatric patients.

7. Respondent is participating in a geriatric two-year fellowship program at the University of North Texas Health Science Center and has approximately eighteen months remaining and plans also to fulfill his certification in palliative care.

8. The Board has reviewed nine (9) patient charts and finds the following deficiencies in one form or another among these nine (9) charts: failure to properly chart the performance of and results of physical examinations; failure to indicate in the chart the rationale and reasons for prescribing narcotic medications; inadequate charting of treatment planning; prescribing of large quantities of controlled substances, namely Valium and Vicodin, without reflecting in the chart adequate initial and interval medical histories, adequate medical examinations, or medically appropriate diagnostic testing/studies.

9. In some instances there is inadequate charting to reflect proper medical indication for the prescribing of Valium and Vicodin.

CONCLUSIONS OF LAW

Based on the above findings of facts, the Board concludes the following:

1. Respondent has violated Section 3.08(18) of the Medical Practice Act ("the Act"), V.A.C.S., article 4495b, which authorizes the Board to take disciplinary action against Respondent based on Respondent's professional failure to practice medicine in an acceptable manner consistent

with public health and welfare.

2. Section 4.02(h) of the Act authorizes the Board to resolve and make a disposition of this matter through an Agreed Order.

3. Section 4.02(i) of the Act Provides that this Agreed Order is a settlement order under the Texas Rules of Civil Evidence for purposes of civil litigation.

4. Section 4.12 of the Act authorizes the Board to take action in regard to Respondent and Respondent's medical license as set forth below.

ORDER

Based on the above findings of fact and conclusions of law, the Board ORDERS that Respondent's medical license is hereby RESTRICTED under the following terms and conditions for three (3) years from the date of the signing of this Agreed Order by the presiding officer of the Board:

1. Respondent shall attend at least fifty (50) hours per year of Continuing Medical Education (CME) approved for Category I credits by the American Medical Association or by the American Osteopathic Association. At least twenty (20) hours shall be in the area of pain management. Each year Respondent shall submit to the Board's Director of Compliance proof of the prior year's CME attendance by the Order's anniversary date. Respondent shall submit proof to the Board of CME hours attended in the current year even though such may not meet the 50-hour requirement. A copy of the attendance certificates issued or a detailed report which can be readily verified by the Board shall satisfy this requirement.

2. Respondent's medical practice, including any office and surgical practice, shall be monitored by a licensed Texas physician approved in advance in writing by the Executive Director

of the Board based on the monitoring physician's licensure status and history, general qualifications, area of specialty, business affiliation with Respondent, and specialty certifications and training. Respondent shall provide a copy of this Agreed Order to the monitoring physician and shall allow the monitoring physician random access to Respondent's patient records, patient billing records, and offices. The monitoring physician shall review Respondent's patient medical records, patient billing records, and offices. The monitoring physician shall review Respondent's medical practice and shall counsel Respondent on any perceived deficiencies. Respondent shall follow the appropriate guidance provided by the monitoring physician and shall ensure that quarterly reports from the monitoring physician are routed in a timely manner to Board representative through the Director of Compliance for the Board. Any costs incurred by the monitoring physician shall be the responsibility of Respondent and shall not be charged to patients. To request approval of a monitoring physician, Respondent shall submit in writing to the Director of Compliance of the Board the names and practice addresses of at least three physicians who are willing and able to effectively monitor Respondent's office and surgical practice. The monitoring physician may be changed at any time by the Executive Director of the Board pursuant to a written request by Respondent based upon good cause shown by Respondent for such a change. This monitoring requirement shall include any period of time in which Respondent is a graduate fellow, resident, or receiving structured post graduate medical training. While in such training program(s), a specific monitor shall not be required, but the training program shall perform quarterly evaluations and provide copies to the Board.

3. Respondent shall maintain adequate medical records on all patient office visits, consultations, surgeries performed, drugs provided, and treatment rendered by Respondent. These records will include at a minimum, the patient's name and address, vital signs and statistics, chief

complaints, history and physical findings, diagnosis and basis for diagnosis, treatment plan for each patient visit or operative procedure, a notation of all medications prescribed or otherwise provided to the patient including the quantity, dosage, and rationale for providing the medications, and detailed records of all follow-up visits. Each visit shall be noted in the patient record and dated accordingly. Respondent shall make all patient medical records available for inspection and copying upon the oral or written request of the Board consultants, investigators, compliance officers, attorneys, or the Executive Director of the Board.

4. Respondent shall not prescribe Schedule II medications for patients in a general office setting, but shall prescribe Schedule II medications only for hospice and long-term nursing home patients, as appropriate.

5. Respondent shall maintain a logbook for all prescriptions and refills telephoned in by Respondent or at Respondent's direction for controlled substance medications, in chronological order by date. This logbook shall be made available for inspection by compliance officers, investigators, and other representatives of the Board during regular office hours without notice to Respondent. For each controlled substance prescription or refill, Respondent shall legibly record in the logbook the specific dosage and amount of medication authorized, the time and date of the telephone authorization was given, the patient's name, the pharmacy providing the medication, and the medical basis for each prescription or refill.

6. Respondent shall refrain from the prescription or administration of any drug for any patient unless the drug is medically indicated and is prescribed in therapeutic doses. Respondent shall not prescribe, administer, or dispense any drug with a potential for abuse to any person unless there is a legitimate medical and therapeutic need after Respondent has taken an appropriate medical

history and conducted an examination which is clinically adequate to determine a proper diagnosis and course of treatment. Respondent shall conduct adequate follow-up examinations on all patients to determine whether the course of treatment, including the prescribing of drugs, is appropriate for the medical condition of the patient and to determine if the drug regimen is being prescribed or administered should be modified in any way.

7. Respondent will become familiar with and incorporate into his practice Board Rules 170.1-170.2, dealing with chronic pain management.

8. To verify that Respondent has complied with and is in compliance with the terms and conditions of this Agreed Order, Respondent shall fully cooperate with the Board and Board staff, including but not limited to, Board attorneys, investigators, compliance officers, consultants, and other such employees or agents of the Board in any way involved with the investigation, review, or monitoring associated with Respondent's compliance with this Agreed Order. Failure to cooperate as required by this paragraph and the terms of this Agreed Order may constitute a basis for disciplinary action against Respondent pursuant to Sections 3.08, 4.01, and 4.11 of the Act.

9. Respondent shall personally appear before the Board, a committee of the Board, or a panel of Board representatives, at least two (2) times each year that Respondent is under the terms and conditions of this Agreed Order. Such appearances shall be for the purpose of reporting on and addressing issues related to Respondent's compliance with the terms and conditions of this Agreed Order.

10. Respondent shall personally appear before the Board, a committee of the Board, or panel of Board representatives, upon written request mailed to Respondent's last known address on file with the Board at least ten (10) calendar days before the requested appearance date. Such

appearances shall be for the purpose of reporting on and addressing issues related to Respondent's compliance with the terms and conditions of this Agreed Order.

11. Respondent shall give a copy of this Agreed Order to all hospitals, nursing homes, treatment facilities, and other health care entities where Respondent has privileges, has applied for privileges, or applies for privileges.

12. Respondent shall ensure that any inquires which are made by any person or entity through any means to Respondent or Respondent's employees regarding Respondent's Texas medical licensure status are answered by accurate reference to this Agreed Order.

13. Upon request by any person or entity, either orally or in writing, Respondent shall provide a complete and legible copy of this Agreed Order to the requesting party within ten (10) calendar days of the request.

14. The time period of this Order shall be extended for any period of time in which Respondent subsequently resides or practices medicine outside the State of Texas, is in official retired status with the Board, or for any period during which Respondent's license is subsequently canceled for nonpayment of licensure fees. If Respondent leaves Texas to live or practice medicine elsewhere, Respondent shall immediately notify the Board in writing of the dates of Respondent's departure from and subsequent return to Texas. Upon Respondent's return to practice in Texas or Respondent's relicensure, Respondent shall be required to comply with the terms of this Order for the period of time remaining on the Order when Respondent left the practice of medicine in Texas, retired, or had his license canceled for nonpayment of licensure fees.

15. Respondent shall comply with all the provisions of the Medical Practice Act ("the Act"), V.A.C.S., article 4495b, and other statutes regulating the practice of medicine, as is required

by law for physicians licensed by the Board.

16. Respondent shall inform the Board in writing of any change of Respondent's office or mailing address within ten (10) days of the address change. This information shall be submitted to the Verification Department and the Director of Compliance for the Board. Failure to provide such information in a timely manner may constitute a basis for disciplinary action by the Board against Respondent pursuant to Sections 3.08, 4.01 and 4.11 of the Act.

17. Any violation of the terms, conditions or requirements of this Order by Respondent may constitute a basis for disciplinary action by the Board against Respondent pursuant to Sections 3.08, 4.01 and 4.11 of the Act. Any violation of the terms, conditions, or requirements of this Order by Respondent may constitute evidence of unprofessional or dishonorable conduct likely to deceive or defraud the public or injure the public.

18. The above-referenced conditions shall continue in full force and effect without opportunity for amendment, except for clear error in drafting, for twelve (12) months following entry of this Order. If, after passage of the twelve month period, Respondent wishes to seek amendment or termination of these conditions, Respondent may petition the Board in writing. The Board may inquire into the request and may, in its sole discretion, grant or deny the petition. Petitions for modifying or terminating may be filed only once a year thereafter.

19. Entry by the Board of this Agreed Order shall also constitute a PUBLIC REPRIMAND and Respondent is hereby publicly reprimanded.

RESPONDENT WAIVES ANY FURTHER HEARING OR APPEALS TO THE BOARD OR TO ANY COURT IN REGARD TO ALL TERMS AND CONDITIONS OF THIS AGREED

ORDER. NOTHING IN THIS ORDER SHALL BE DEEMED A WAIVER OF RESPONDENT'S RIGHTS UNDER STATUTE OR THE UNITED STATES OR TEXAS CONSTITUTIONS TO APPEAL AN ORDER OR ACTION OF THE BOARD SUBSEQUENT TO THIS AGREED ORDER EXCEPT AS RESPONDENT MAY HAVE OTHERWISE AGREED TO HEREIN. RESPONDENT AGREES THAT THIS IS A FINAL ORDER. THIS ORDER IS A PUBLIC RECORD.

I, ADOLPHUS RAY LEWIS, D.O., HAVE READ AND UNDERSTAND THE FOREGOING AGREED ORDER. I UNDERSTAND THAT BY SIGNING, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THIS AGREED ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATE: 7/28, 1998.

A. Ray Lewis DO

ADOLPHUS RAY LEWIS, D.O.
RESPONDENT

STATE OF TEXAS

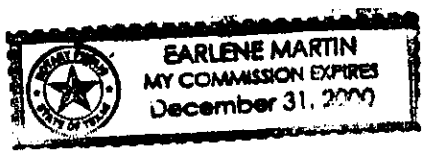
COUNTY OF Tarrant

BEFORE ME, the undersigned Notary Public, on this day personally appeared Adolphus Ray Lewis, D.O., known to me to be the person whose name is subscribed to this instrument, an Agreed Order, and who after being by me duly sworn, on oath, stated that he executed the same for all purposes expressed therein.

Given under my hand and official seal and office this 28th day of July, 1998.

Earlene Martin
Signature of Notary Public

(Notary Seal)



EARLENE Martin
Printed or typed name of Notary Public

My commission expires: 12-31-2000

SIGNED AND ENTERED by the presiding officer of the Texas State Board of Medical Examiners on this 22 day of August 1998.

William H. Fleming, III, M.D.
President, Texas State Board of
Medical Examiners

H-2532

IN THE MATTER OF	§	BEFORE THE
	§	
THE LICENSE OF	§	TEXAS STATE BOARD
	§	
ADOLPHUS LEWIS, D.O.	§	OF MEDICAL EXAMINERS

ORDER

On this the 15 day of October, 1999, came on to be heard before the Texas State Board of Medical Examiners ("the Board" or "the Texas Board"), duly in session the matter of the license of Adolphus Lewis, D.O. ("Respondent"). On October 1, 1999 Respondent appeared in person, without counsel, before representatives of the Board to report on and address issues related to Respondent's compliance with the terms and conditions of an Order entered on August 22, 1998 pertaining to Respondent's Texas medical license H-2532.

The Board was represented at Respondent's appearance by Larry Price, D.O., Mrs. Ernest Angelo, Jr., and Jose Manuel Benavides, M.D., all of whom are members of the Board. Upon recommendation of the Board's representatives, and with the consent and request of Respondent, the Board makes the following findings of fact and enters this Order as set forth herein:

FINDINGS OF FACT

A. On August 22, 1998, the Board entered an Agreed Order, which restricted Respondent's medical license for three (3) years, under certain terms and conditions, based on the following Findings of Fact.

1. Respondent, Adolphus Ray Lewis, D.O. holds Texas Medical license H-2532.
2. The Board has jurisdiction over the subject matter and Respondent. Respondent received all notice, which may be required by law and by the rules of the Board. All jurisdictional requirements have been satisfied.

3. Respondent was issued a Texas medical license by the Texas State Board of Medical Examiners ("the Board") on February 5, 1988.
4. Respondent routinely treats chronic pain patients and patients who have otherwise failed alternative treatment modalities.
5. Respondent is the Medical Director for a hospice and in those activities, treats terminally ill patients.
6. Respondent also focuses his practice on geriatric patients.
7. Respondent is participating in a geriatric two-year fellowship program at the University of North Texas Health Science Center and has approximately eighteen months remaining and plans to fulfill his certification in palliative care.
8. The Board has reviewed nine (9) patient charts and finds the following deficiencies in one form or another among these nine (9) charts: failure to properly chart the performance of and results of physical examinations; failure to indicate in the chart, the rationale and reasons for prescribing narcotic medications; inadequate charting of treatment planning; prescribing of large quantities of controlled substances, namely Valium and Vicodin, without reflecting in the chart adequate initial and interval medical histories, adequate medical examinations, or medically appropriate diagnostic testing/studies.
9. In some instances there is inadequate charting to reflect proper medical indication for the prescribing of Valium and Vicodin.

B. Based on information available on October 1, 1999 the Board's representatives recommend that the Order be modified to order the termination of the Order upon staff's receipt of documented evidence that Respondent has successfully completed the fellowship program at TNTHSC.

ORDER

Based on available information, the above Findings of Fact, and the recommendation of the Board's representatives, the Board ORDERS that the August 22, 1998 Agreed Order shall be TERMINATED upon the Board's receipt of documented evidence that Respondent has successfully completed the Geriatric Fellowship Program at the University of North Texas Health Science Center.

All other provisions of the August 22, 1998 Agreed Order remain in full force and effect until superseded by a subsequent Order of the Board.

THIS IS A PUBLIC RECORD.

Signed and entered on this the 15 day of October, 1999.

for William H. Fleming, III, M.D.
President, Texas State Board of
Medical Examiners

Cause Number 17-218598-06

Patricia Webb Coffey, Individually, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased, and Charles William Webb, Individually, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased	§	In the District Court
Plaintiffs,	§	Tarrant County, Texas
vs.	§	
Centers for Long Term Care of Richland Hills, Inc. d/b/a CLC Richland Hills, CLC Richland Hills, Lawrence A. Whaley, M.D., Ireti Odubela, F.N.P., A. Ray Lewis, D.O., and Gary Trebert,	§	17th Judicial District
Defendants.	§	

FINAL JUDGMENT

On July 28, 2008, this Cause came on to be heard.

APPEARANCES

Plaintiffs Patricia Webb Coffey, Individually, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased, and Charles William Webb, Individually, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased appeared in person and by attorney of record and announced ready for trial.

Centers for Long Term Care of Richland Hills, Inc. d/b/a CLC Richland Hills, CLC Richland Hills (hereafter "CLC Richland Hills"), having been duly cited and having notice of the trial of the cause, did not appear for trial. Prior to trial, on May 16, 2008, the Court, granted a Rule 12 motion,

pursuant to Texas Rule of Civil Procedure 12, against CLC Richland Hills and struck all of its pleadings. Because of the Rule 12 Motion and because of CLC Richland Hill's failure to appear for trial, the Court granted an Interlocutory Judgment by Default against CLC Richland Hills.

Defendant Lawrence A. Whaley (hereafter "Whaley") appeared in person and by attorney of record and announced ready for trial.

Defendant Ireti Odubela, F.N.P. (hereafter "Odubela") appeared in person and by attorney of record and announced ready for trial.

Defendant A. Ray Lewis, D.O. (hereafter "Lewis") appeared in person and by attorney of record and announced ready for trial.

Defendant Gary Trebert (hereafter "Trebert"), having been duly cited and having notice of the trial setting, did not appear for trial. The Court finds that Plaintiffs are entitled to judgment against Trebert.

TRIAL PROCEEDINGS

A jury of twelve, good and lawful men and women were duly tested, selected, paneled, and sworn, and trial began on July 28, 2008.

At the conclusion of the evidence, the court submitted questions of fact in the case to the jury. The charge of the Court, the supplemental charge of the Court, and the verdict are incorporated for all purposes by reference. The jury answered all of the questions unanimously.

The jury found, in answer to question one, that the negligence of Defendant Lewis proximately caused the death of Mable Webb. The Court found that, as a matter of law, the negligence of CLC Richland Hills proximately caused the death of Mable Webb.

The jury also answered "no" to question one that asked whether the negligence, if any, of Whaley proximately caused the death of Mable Webb.

The jury also answered "no" to question one that asked whether the negligence, if any, of Odubela proximately caused the death of Mable Webb.

The jury found, in answer to question two, that 49% of the responsibility that caused the death of Mable Webb was attributable to Lewis, and 51% was attributable to CLC Richland Hills.

The jury found, in answer to question three, that $500,000.00 would have fairly and reasonably compensated Mable Webb for her pain, mental anguish, and physical impairment.

The jury found, in answer to question four, that Plaintiff Patricia Webb Coffey sustained $230,000.00 in past damages for loss of companionship and society and mental anguish.

The jury found, in answer to question four, that Plaintiff Patricia Webb Coffey will, in all reasonable probability, sustain $70,000.00 in future damages for loss of companionship and society and mental anguish.

The jury found, in answer to question five, that Plaintiff Charles William Webb sustained $50,000.00 in past damages for loss of companionship and society and mental anguish.

The jury found, in answer to question five, that Plaintiff Charles William Webb will, in all reasonable probability sustain $50,000.00 in future damages for loss of companionship and society and mental anguish.

The jury found by clear and convincing evidence, in answer to question six, that the harm to Mable Webb resulted from an act or omission by Lewis which, when viewed objectively from the standpoint of Lewis at the time of its occurrence, involved an extreme degree of risk, considering the probability and magnitude of the potential harm to others; and of which Lewis

had actual, subjective awareness of the risk involved, but nevertheless proceeded with conscious indifference to the rights, safety and welfare of others.

The jury found in a supplemental jury charge, in answer to question number eight, that $1,000,000.00 should be assessed against Lewis and awarded to Mable Webb, $100,000.00 should be assessed against Lewis and awarded to Plaintiff Patricia Coffey, and $100,000.00 should be assessed against Lewis and awarded to Plaintiff Charles William Webb.

The jury reached its verdict on August 6, 2008. The Court accepted the jury's verdict in open Court on August 6, 2008. Based on that verdict and the proceedings, the Court enters this Judgment.

COURT FINDINGS AND CONCLUSIONS OF LAW

The Court makes the following findings and conclusions as a matter of law:

A. The Court finds that Defendant Lewis is a Physician as that term is defined Texas Civil Practice & Remedies Code § 74.001 (a)(23).

B. The Court further finds that Tex. Civ. Prac. & Rem. Code § 74.301 limits the actual non-economic damages found by the jury, in answer to questions three, four, and five, and assessed against Defendant Lewis to $250,000.00. Plaintiffs shall be entitled to prejudgment interest and taxable court costs above this limitation. The amounts reflected in this Judgment apply the limitation set forth in Tex. Civ. Prac. & Rem. Code § 74.301.

C. The Court finds that Tex. Civ. Prac. & Rem. Code § 74.303 has a limitation on all damages, including exemplary damages, that, when applied pursuant to Tex. Civ. Prac. & Rem. Code § 74.303(b), is approximately $1,747,439.02. This limitation does not cap or limit post judgment interest. This limitation set forth in Tex. Civ. Prac. & Rem. Code § 74.303 is higher than the sums set forth in this judgment.

D. The Court further finds that Chapter 74 of the Texas Civil Practice and Remedies Code does not apply to Defendants CLC Richland Hills or Defendant Trebert.

E. The Court further finds that Defendants Trebert and CLC Richland Hills are responsible for the conduct of each other as they operate as a single business enterprise, joint venture, or joint enterprise. The Court further finds that Defendants Trebert and CLC Richland Hills are engaged in a concert of action, civil conspiracy, and are principal and agent of each other. The Court further finds that Defendants CLC Richland Hills and Trebert ratified the conduct of each other and engaged in non-delegable duties. The Court further finds that Defendant Trebert is a vice-principal of CLC Richland Hills.

F. The Court further finds that the corporate veil between CLC Richland Hills and Trebert should be disregarded CLC Richland Hill's corporate form was used as a shield to perpetrate fraud; CLC Richland Hills and Trebert are alter egos of each other; the corporate form of CLC Richland Hills was being used to evade legal obligations; and CLC Richland Hills was inadequately capitalized so as to work injustice.

G. The Court further finds that a fiduciary relationship existed between Mable Webb, on one hand, and Defendants Trebert and CLC Richland Hills on the other hand. The Court further finds that Defendants Trebert and CLC Richland Hills breached the fiduciary duty owed to Mable Webb, and such breach resulted in an injury to Mable Webb and a benefit to Defendants Trebert and CLC Richland Hills.

H. The Court further finds that, while acting in a fiduciary capacity to Mable Webb, Defendants Trebert and CLC Richland Hills committed common law fraud.

I. The Court further finds that Defendants Trebert and CLC Richland Hills committed willful and malicious injury.

It appears to the Court, after having heard the evidence and arguments of counsel, that Plaintiffs are entitled to judgment against Defendants CLC Richland Hills and Trebert.

It further appears to the Court that the verdict of the jury was for the Plaintiffs and against Defendant Lewis.

It further appears to the Court that the verdict of the jury was for Defendant Whaley and against Plaintiffs.

It further appears to the Court that the verdict of the jury was for Defendant Odubela and against Plaintiffs.

It is the opinion of the Court, after having heard the evidence in this cause, argument of counsel, and based on the verdict of the jury, that judgment should be rendered in favor of the Plaintiffs and against Defendants CLC Richland Hills, Trebert and Lewis; and it is further the opinion of the Court that judgment should be rendered in favor of Defendants Whaley and Odubela and against Plaintiffs.

DEFENDANT LEWIS

1. IT IS THEREFORE ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased, and Charles William Webb, As Legal Representative and Heir of the Estate of Mable Ann Webb have and recover actual damages from Defendant A. Ray Lewis, D.O. in the amount of $139, 200.00 (One Hundred Thirty Nine Thousand Two Hundred Dollars), and IT IS ORDERED, ADJUDGED, and DECREED that prejudgment interest at the rate of 5%, computed as

ADJUDGED, and DECREED that prejudgment interest at the rate of 5% [illegible]

simple interest, accrues on this amount beginning on June 27, 2006 (date this suit was filed) and ends on the day preceding the date this judgment is signed by the Court. This amounts to $19.07 per day in prejudgment intereset;

2. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, Individually, have and recover past actual damages from Defendant A. Ray Lewis, D.O., in the amount of $63,075.00 (Sixty Three Thousand and Seventy Five Dollars) and future actual damages in the amount of $18,850.00 (Eighteen Thousand Eight Hundred and Fifty Dollars), and IT IS ORDERED, ADJUDGED AND DECREED that prejudgment interest at the rate of 5%, computed as simple interest, accrues on the past actual damages beginning on June 27, 2006 (date this suit was filed) and ends on the day preceding the date this judgment is signed by the Court. This amounts to $8.64 per day in prejudgment interest;

3. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Charles William Webb, Individually, have and recover past actual damages from Defendant A. Ray Lewis, D.O., in the amount of $15,225.00 (Fifteen Thousand Two Hundred and Twenty-five Dollars) and future actual damages in the amount of $ 13,650.00 (Thirteen Thousand Six Hundred and Fifty Dollars), and IT IS ORDERED, ADJUDGED AND DECREED that prejudgment interest at the rate of 5%, computed as simple interest, accrues on the past actual damages beginning on June 27, 2006 (date this suit was filed) and ends on the day preceding the date this judgment is signed by the Court. This amounts to $2.09 per day in prejudgment interest;

4. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, As Legal Representative of the Estate of Mable Ann Webb, Deceased and Charles William Webb, As Legal Representative of the Estate of Mable Ann Webb, Deceased have

and recover exemplary damages from A. Ray Lewis the sum of $1,000,000.00 (One Million Dollars);

5. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, Individually, have and recover exemplary damages from Lewis the sum of $100,000.00 (One Hundred Thousand Dollars);

6. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Charles William Webb, Individually, have and recover exemplary damages from Lewis the sum of $100,000.00 (One Hundred Thousand Dollars);

7. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that costs of court in the amount of $3,881.00 are adjudged Defendants Lewis, for which let execution issue;

8. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the total amount of the judgment as described in Sections 1-7 of this Judgment will bear post judgment interest at the rate of 5% compounded annually from the date this judgment is signed until paid. This includes post judgment interest on the past and future actual damages described in Sections 1-3 of this Judgment, prejudgment interest as described in Sections 1-3, and exemplary damages as described in Sections 4-6 of this Judgment, and court costs as described in Section 7 of this Judgment.

DEFENDANTS CLC RICHLAND HILLS AND TREBERT

9. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Defendants Trebert and CLC Richland Hills are responsible for the conduct of each other. They operate as a single business enterprise, joint venture, and/or joint enterprise. Further, Defendants CLC Richland Hills and Trebert are engaged in a concert of action, civil conspiracy, and are principal and

agent of each other. Further, Defendants CLC Richland Hills and Trebert ratified the conduct of each other and engaged in non-delegable duties;

10. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Defendant Trebert is a vice-principal of CLC Richland Hills;

11. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Defendants CLC Richland Hills and Trebert are alter egos of each other, and that the corporate veil between CLC Richland Hills and Trebert is disregarded;

12. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the corporate form of CLC Richland Hills was used as a shield to perpetrate fraud, and the corporate veil between CLC Richland Hills and Trebert is disregarded;

13. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the corporate form of CLC Richland Hills was being used to evade legal obligations; and the corporate veil between CLC Richland Hills and Trebert is disregarded;

14. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that CLC Richland Hills was inadequately capitalized so as to work injustice; and the corporate veil between CLC Richland Hills and Trebert is disregarded;

15. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that a fiduciary relationship existed between Mable Webb and Defendants Trebert and CLC Richland Hills, and IT IS ORDERED that Defendants Trebert and CLC Richland Hills breached the fiduciary duty owed to Mable Webb, and such breach resulted in an injury to Mable Webb and a benefit to Defendants Trebert and CLC Richland Hills;

inadequately capitalized so as to work injustice; and the corporate veil

16. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that while acting in a fiduciary capacity to Mable Webb, Defendants Trebert and CLC Richland Hills committed common law fraud;

17. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Defendants Trebert and CLC Richland Hills committed willful and malicious injury;

18. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased, and Charles William Webb, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased, have and recover actual damages from CLC Richland Hills and Trebert, jointly and severally, in the amount of $361,000 (Three Hundred Sixty One Thousand Dollars), and IT IS ORDERED, ADJUDGED AND DECREED that prejudgment interest at the rate of 5%, computed as simple interest, accrues on this amount beginning on June 27, 2006 (date this suit was filed) and ends on the day preceding the date this judgment is signed by the Court;

19. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, Individually have and recover past actual damages from Defendants CLC Richland Hills and Trebert, jointly and severally, in the amount of $ 166, 897.50 (One Hundred Sixty Six Thousand Eight Hundred Ninety Seven Dollars and Fifty Cents) and future actual damages in the amount of $ 49, 852.50 (Forty Nine Thousand Eight Hundred Fifty Two Dollars and Fifty Cents), and IT IS ORDERED, ADJUDGED AND DECREED that prejudgment interest at the rate of 5%, computed as simple interest, accrues on the past

actual damages beginning on June 27, 2006 (date this suit was filed) and ends on the day preceding the date this judgment is signed by the Court;

20. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Charles William Webb, Individually, have and recover past actual damages from CLC Richland Hills and Trebert, jointly and severally, in the amount of $36,125.00 (Thirty Six Thousand One Hundred Twenty Five Dollars) and future actual damages in the amount of $36,125.00 (Thirty Six Thousand One Hundred Twenty Five Dollars), and IT IS ORDERED that prejudgment interest at the rate of 5%, computed as simple interest, accrues on the past actual damages beginning on June 27, 2006 (date this suit was filed) and ends on the day preceding the date this judgment is signed by the Court;

21. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased and Charles William Webb, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased have and recover exemplary damages from CLC Richland Hills the sum of $1,000,000.00 (One Million Dollars);

22. IT IS FURTHER ORDERED, ADJUDGED AND DECREED by the Court that Plaintiff Patricia Webb Coffey, Individually, have and recover exemplary damages from CLC Richland Hills the sum of $100,000.00 (One Hundred Thousand Dollars);

23. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Charles William Webb, Individually, have and recover exemplary damages from CLC Richland Hills the sum of $100,000.00 (One Hundred Thousand Dollars);

Charles William Webb, As Legal Representative and Heir of the Estate of

24. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, As Legal Representative of the Estate of Mable Ann Webb, Deceased and Charles William Webb, As Legal Representative of the Estate of Mable Ann Webb, Deceased have and recover exemplary damages from Trebert the sum of $1,000,000.00 (One million dollars);

25. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Patricia Webb Coffey, Individually, have and recover exemplary damages from Trebert the sum of $100,000.00 (One Hundred Thousand Dollars);

26. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Charles William Webb, Individually, have and recover exemplary damages from Trebert the sum of $100,000.00 (One Hundred Thousand Dollars);

27. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the total amount of the judgment as described in Sections 18-25 of this Judgment will bear post judgment interest at the rate of 5% compounded annually from the date this judgment is signed until paid. This includes post judgment interest on the past and future actual damages described in Sections 18-20 of this Judgment, prejudgment interest as described in Sections 18-20, and exemplary damages as described in Sections 21-25 of this Judgment.

DEFENDANTS WHALEY AND ODUBELA

28. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiffs Patricia Webb Coffey, Individually, As Legal Representative and Heir of the Estate of Mable Ann Webb, Deceased, and Charles William Webb, Deceased, take nothing by their suit from Defendants Whaley and Odubela.

FINAL JUDGMENT/WRITS AND EXECUTION

29. All writs and processes for the enforcement and collection of this judgment or the costs of court may issue as necessary.

30. All other relief not expressly granted in this judgment is denied. The judgment finally disposes of all parties and claims and is appealable.

SIGNED ON June 25, 2008

JUDGE PRESIDING